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ABSTRACT

Historically, the financial responsibility for caring for those with mental illness has shifted back and forth from the local community, to the state, to the federal government. Today states provide the vast majority of the funds to the state mental health agencies and oversee local governments and most private resources for mental health funding. To establish financially sound and responsive mental health systems, state legislatures should: (1) develop effective fiscal/management models; (2) oversee the coordination of services and provide the legal framework for service delivery; (3) examine costs involved in providing care for those with mental illness; (4) use an improved system of contract management, budgeting, and information management; (5) remove specific eligibility requirements and encourage states and localities to meet the needs of the mentally ill; (6) encourage private insurance programs to provide financial incentives for the provision of care in the least restrictive, least costly environments; and (7) encourage creative and efficient models for improving mental health financing. Financing trends could produce significant change in the future reimbursement of mental health care with states being challenged to create a funding mix for mental health and supportive services and to develop cost-effective program implementation. (Specific program and legislative responses of the states are described.) (ABL)

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MENTAL HEALTH PROJECT

Human Servies Series

Making Ends Meet: Maximizing the Mental Health Dollar

by

Rebecca T. Craig

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MAKING ENDS MEET:
MAXIMIZING THE MENTAL HEALTH DOLLAR

INTRODUCTION

Mental illness costs American society an estimated $73 billion each year. Mental illness disorders represented the third most costly class of health care expenditures nationwide in 1980. Only circulatory disorders--including heart disease, stroke and hypertension--and digestive system disorders were more costly. (1, p. 5) Almost half of the mental health costs are for direct treatment and support services. The indirect costs of lost productivity and employment are additional costs to society. Approximately 43 percent of the direct costs are for persons with chronic and serious mental illness--many of whom are institutionalized in nursing homes or psychiatric hospitals and paid for by federal and state funds. (2, p. 12)

State legislatures generally determine what mental health services will be provided with public dollars and control the amount of funding for public mental health programs within the states. With reduced or eliminated federal funding, legislators are becoming increasingly concerned about the provision of services to those suffering from mental illness. States are struggling to address a variety of mental health funding issues, including: mandated mental health insurance coverage, the appropriate funding distribution between outpatient and inpatient services, trends toward the usage of prospective payment systems or other capitation measures and community care funding disincentives.

HISTORICAL FINANCING OF MENTAL HEALTH CARE (3)

During colonial times, local communities were responsible for the care of those with mental illness. With the development of the state hospital, however, the financing and locus of care was shifted from the local community to the state. The mid-1800s saw the establishment of the state hospital system that was the dominant form of care for the next hundred years. Until the 1960s, 96 percent of all funds for public psychiatric treatment facilities came from state revenues.

Health insurance for the general public came into existence during the Great Depression, ensuring that patients could afford to be treated and that hospitals would get paid. Although insurance plans were initially arranged around general hospitals where mentally ill persons rarely were treated, wage freezes during World War II stimulated a demand for fringe benefit improvements. Health insurance benefits were subsequently expanded, including improved benefits for psychiatric care. In an effort to limit risk, however, providers began to impose their own limits on coverage.

The nation's attitude toward mental illness and the federal government's involvement in the provision of mental health services was affected profoundly during the World War II era. This new awareness, in part, resulted in the passage of the National Mental Health Act of 1946. Although the federal government had funded previously only two types of state-run clinics, the act provided funds for training and research in mental illness. And perhaps most important, the federal government became involved in providing direct aid to states for the establishment of psychiatric clinics for the first time.

The Community Mental Health Centers Act of 1963 shifted a sizable portion of responsibility for mentally ill persons from the state institutions to the community. A further shift toward federal responsibility for this population occurred with the development of Medicare, Medicaid and Title XVI Amendments to the Social Security Act. Although limitations were immediately imposed on the mental health benefits of these programs, opportunities enabled states to shift much of the funding burden to the federal government. However, the Mental Health Systems Act of 1980, the creation of the block grant mechanism in the Omnibus Budget Reconciliation Act of 1981 and the climate during the Reagan

administration forced the states to assume again a greater role in the care and treatment of persons suffering from mental illness.

With this shifting back and forth of responsibility for mentally ill persons, financing of mental health services has become a complicated mix of mechanisms and systems that varies from state to state. The lack of consistent and adequate financing for mental health care has contributed to major gaps in the service system. In many states, limited cooperation and coordination between the levels of government has resulted in the shifting and dumping of mentally ill persons between system levels. Also, certain aspects of federal, state, local and private sector involvement have served as disincentives to effective community care and barred needy individuals from participation in programs.

STATE, LOCAL AND PRIVATE MENTAL HEALTH FUNDING SOURCES

States are the centerpiece for the mental health service system. Not only do they provide the vast majority of the funds to the state mental health agencies, they also oversee local governments and most private resources for mental health funding. The major state role in mental health financing is to appropriate money to state mental health agencies and other related agencies. Often, state legislatures specify what services are to be provided and to what populations. The block grant system of federal fund allocation has broadened further the states' power by increasing their control over federal spending for mental health programs.

State Government. States supplied over 78 percent of the funds to support state mental health agencies in 1985. Generally, states appropriate funds to state mental health agencies, which distribute the money to state mental hospitals and to local agencies, which deliver services to the community. These agencies may be public or private providers contracted by the state to provide specific services. States further influence mental health financing by passing laws that regulate standards for public and private providers and third-party insurers. (4, p. 5)

Nationwide, state mental health agencies directly controlled and administered more than $8.3 billion dollars for mental health services in FY 1985, including federal funds. As a percentage of total state revenues, funding for mental health services averaged 1.92 percent, with a high of 3.42 percent in New York to a low of 0.38 percent in Alaska. The per capita expenditure varied dramatically, from a high of $90.12 in New York to a low of $8.38 in Puerto Rico. (4, pp. 3-5)

Local Government. Local government participation in mental health financing can be divided into five different models, depending on how services are organized in each state: (5, p. D-3)

- Mental health services are funded completely by the state, which provides mental health services directly or through private contractual agreements.
- The counties share funding responsibility for mental health services with the state, which provides the services directly or through private contractual agreements.
- The counties share with the state in funding mental health services, which are provided by the counties or by local mental health boards.
- The state and county governments jointly provide mental health services, and counties share in funding local mental health services.
- County and state governments provide mental health services primarily through public contractual arrangements and share in the funding of local mental health services.

While local mental health boards or governmental units participate in mental health financing through administrative control over funding, direct delivery or contracting of services and the establishment of priorities, the actual dollar contribution is small. Of the amount spent by all levels of

government to care for those with serious mental illness in 1983, only 2.7 percent was provided by local government. However, approximately half of the states use matching formulas to distribute mental health funds to counties and some states also are giving local government increased control over financing care. (6, p. 64)

Private Foundations. Although public dollars have dominated service funding for those with mental illness for over a hundred years, there has been a rapid growth in private involvement over the past three decades. The United States has some 23,000 foundations with over $50 billion in resources that provide $4 billion in grants each year, of which $700 million goes to health-related projects. Foundations have been influential in mental health policy by strategically targeting programs and issues not generally supported by government, including innovations in mental health service delivery and the education of mental health professionals. (7, p. 1190)

Insurance. Most private insurance plans cover inpatient psychiatric care for 90 days and offer limited payment for some of the services provided by community mental health centers and other public programs. Insurance policies tend to discourage the use of hospital alternatives because of caps on outpatient care through limitations on office visits or amounts paid per visit. In most plans, the patient must pay half of the outpatient costs, compared to 20 percent for other illnesses. (8, p. 82) Mental health services account for approximately 20 to 25 percent of health care claims, a 15 percent rise in the past two years. In an effort to control costs, third-party payers are expected to increase efforts to shift more costs of mental health coverage to consumers in the future. (9, p. 4)

Insurance reimbursement for mental health services generally covers children under 18 who are included under the family's policy. Children without insurance coverage and adults, on the other hand, are usually cared for by the public system. Many adults with serious mental disabilities are unable to hold down jobs long enough to obtain private insurance coverage or they have illnesses so serious that they quickly exhaust their benefit limit. Although a recent court decision determined that a plantiff suffering from manic depression was entitled to the same medical benefits as other biological illnesses, it is unlikely that private insurance will be a significant source of funding for those with serious mental illness in the future.

FEDERAL MENTAL HEALTH FUNDING SOURCES

One of the major sources of funding for those with serious mental illness is federal supports provided under the Social Security Act, including Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicare and Medicaid. The federal government provides 14 percent of the $8.3 billion expended annually on mental health services by state mental health agencies (SMHA). Medicaid dollars constitute the largest proportion of SMHA revenues from federal sources, approximately 8.5 percent. The Alcohol, Drug Abuse and Mental Health Block Grant provides 3 percent and Medicare 2.2 percent of SMHA's revenues. (4, p. 5)

Federal supports for those with mental illness are divided into several types of programs: entitlements, income supports, block grants and other initiatives. These programs attempt to foster independence in the community through the provision of essential health and health-related services.

Entitlement Programs

In an entitlement program, a specific set of services is provided through a voucher system or social insurance program to persons who meet eligibility criteria. The consumer is restricted to a prescribed set of services and providers, such as Medicaid, Medicare and prepaid health insurance programs.

Medicaid. Medicaid is a state-run medical assistance program operated under federal guidelines that require the provision of basic health and rehabilitation services to low-income families who meet certain categorical and financial criteria. With the implementation of the Medicaid program, the federal government began assuming greater responsibility for the provision of long-term mental health

care, and states were able to capture federal revenues from Medicaid by shifting costs from state hospitals to nursing homes.

The Medicaid program pays for more than 41 percent of all nursing home care, amounting to approximately $9 billion in federal funds. (1, p. 10) Sixty-eight percent of state Medicaid budgets in 1984 were allocated for nursing home care. It is estimated that more than half of the nation's nursing home residents have chronic mental disorders. However, nursing home costs are paid by Medicaid only if the setting is not defined as an Institution for Mental Disease (IMD). A facility will be classified as an IMD if specialized psychiatric services are provided or if more than 50 percent of the patients have a nonorganic mental disease as a primary diagnosis. Nonetheless, Medicaid has become a major source of funds for many state mental health systems, despite its restricted use for those people between 21 and 65 years who are in an IMD.

As state and federal Medicaid costs have risen, policymakers have attempted to contain rising nursing home expenditures. Two Medicaid waiver programs, the home- and community-based services waiver (Section 2176) and the freedom-of-choice waiver (Section 2175), were established under the Omnibus Budget Reconciliation Act of 1981 to shift care from nursing homes. These waivers generally have been unavailable, although waivers recently were required to facilitate a large community mental health demonstration funded by the Robert Wood Johnson Foundation.

Medicare. Medicare is a federal health insurance program for persons 65 and older, or others with certain disabilities. While providing broad coverage for a variety of health services and products, Medicare is limited with respect to psychiatric care. Until the passage of the Omnibus Budget Reconciliation Act of 1987, the Hospital Insurance section (Medicare Part A) provided coverage in general hospitals and limited care in freestanding psychiatric hospitals, and the Supplemental Medical Insurance section (Medicare Part B) provided only $250 reimbursement for $500 of outpatient medical care. Increased benefits under Part B were established by statute in 1987 and include an increase in outpatient benefits to $1,100 for $2,200 of care; exemption from limits for the medical management of psychotropic medications; creation of a mental health partial hospitalization services benefit; authorization of psychologist clinic services; and abolishment of the two-year waiting period for renewed disability eligibility.

Income Support Programs

Income support programs transfer cash directly to the individual. The government determines eligibility requirements and the amount of funds to be provided. Income supports, such as SSI, SSDI, Aid to Families with Dependent Children (AFDC) and food stamps are helpful in assisting individuals to obtain nonmedical supports. In addition, SSI and SSDI are crucial in defraying the living expenses of residents in facilities not covered under Medicaid.

Food Stamps and Aid to Families with Dependent Children (AFDC). Food stamps and AFDC provide eligible persons experiencing mental illness with resources needed to survive in the community. The food stamp program is designed to supplement client cash income and residents in group living situations are now eligible to apply for food stamps. AFDC authorizes federal payments to states for providing aid and services to needy families and children.

Social Security Disability Insurance (SSDI). Social Security Disability Insurance (SSDI) replaces wages lost due to severe and extended disability, including mental illness. SSDI is funded totally by the federal government from payroll deductions and is related to the disabled worker's employment history. SSDI provides approximately $1.7 billion to eligible persons with mental illness each year. The average monthly payment is $488 and the recipient has access to Medicare benefits after two years. The standards for disability due to mental impairment were changed in 1985, making SSDI less strict and more responsive to the needs of those with serious mental illness. (1, p. 9)

Supplemental Security Income (SSI). SSI provides funds at subsistence levels to needy, aged, blind and disabled persons who meet uniform, nationwide income and asset eligibility criteria. Eligible

individuals with mental illness receive approximately 23 percent of the $1.3 billion SSI payments each year. SSI payments are obtained from general revenues. The average benefit award is approximately $340 per month; states may elect to supplement this payment. SSI entitles the recipient to Medicaid benefits. The medical impairment criteria and standards for SSI are the same as for SSDI. (1, p. 9)

Block Grants

In 1981, nine federal block grants were created to provide states with a variety of services. The Alcohol, Drug Abuse and Mental Health and the Social Services block grants are the largest federal block grant programs that provide substantial resources for persons with mental illness.

Alcohol, Drug Abuse and Mental Health (ADM) Block Grant. This block grant consolidated a number of federal assistance programs and is of special concern in financing mental health services. Operational funding of community mental health centers for specific services and coordination of mental health and health care are provided by the mental health portion of the grant. States must comply with a number of detailed requirements, and funds are allocated under a formula related to past spending. Despite recent increases, the block grant funds have decreased by 30 percent since 1980, if inflation is taken into account.

Community Development Block Grant (CDBG). The Community Development block grant provides money through the Department of Housing and Urban Development (HUD) to purchase, build or rehabilitate property that would benefit low- and moderate-income persons. This is the federal government's principal program to help communities meet local housing and development needs. These funds also will cover certain services needed to support other block grant opportunities and may be used as seed money for other federal housing programs.

Social Services (Title XX) Block Grant. Title XX, the largest block grant to the states, is used primarily to prevent institutionalization by providing a range of community-based services. The Social Services block grant funds numerous community or social services. Portions of its $2.7 billion national appropriation have provided states with support services for persons with serious mental illness. The portion of funds allocated for those with mental illness varies from state to state and is often difficult to determine because of insufficient data.

Other Federal Programs

The Department of Health and Human Services, including the National Institute of Mental Health (NIMH), the Department of Housing and Urban Development (HUD) and other federal agencies provide additional resources to support mental health services. These programs are provided through various mechanisms, including housing initiatives, demonstrations and grants.

GENERAL LEGISLATIVE GUIDELINES

The following broad concepts can provide legislators with general directions for establishing a framework for a financially sound and responsive mental health system.

To promote the most effective utilization of resources and access to existing resources, states need to develop fiscal/management models that make the best use of scarce resources, prioritize the most-in-need populations, coordinate the various funding mechanisms and close in the service system gaps.

States need to oversee the coordination of services and provide the legal framework for service delivery. This coordination and cooperation can be achieved by bringing public and private resources together, providing fiscal incentives for treatment of underserved populations and community care, and providing care to the most diffficult and disabled groups.

State legislatures and mental health agencies need to look at all costs involved in providing care for those with mental illness. Reducing costs in one program may increase costs in another through the transfer of clients from one service arena or delivery system to another.

A better system of contract management, budgeting and management of information is needed in state mental health agencies to coordinate the increasingly complex and decentralized system of mental health care.

Financing of psychiatric and human services should encourage states and localities to meet the needs of mentally ill persons instead of allowing reimbursement to drive the system. Federal, state and private programs should remove specific eligibility requirements and service restrictions that pose obstacles to those with mental illness and serve as disincentives to effective community care.

Private insurance programs should be encouraged to provide financial incentives for the provision of care in the least restrictive, least costly environments. Benefit levels for treatment of mental illness should also be on a par with the treatment of physical illnesses.

States should encourage creative and efficient models for improving mental health financing. For example, states could purchase services from public and private vendors instead of providing services directly. Creative models must be developed to encourage mental health providers to use entrepreneurial means of raising money for those services that are not reimbursed under existing programs. States should explore ways to convert closed or partially closed state hospital facilities and channel accrued revenues directly back into the mental health system.

THE STATES' RESPONSE IN RECENT YEARS

Programs

During the recent years of budgetary constraints, states have taken diverse approaches to financing services for those with mental illness. Four approaches that states have taken to finance community services include: innovative uses of Medicaid and other federal monies, private/public partnerships, interagency agreements and shifting institutional resources to community settings.

Colorado. Colorado formed the Community Housing and Services (CHS) program in 1977 to provide community-based alternatives for its disabled population. This program is the only statewide Public Housing Authority administered through an existing human service agency. CHS began with 80 Section 8 existing certificates provided through HUD. The program has grown to almost 1,000 Section 8 certificates and vouchers in the past 10 years. Another housing alternative offered by HUD uses Single Room Occupancy (SRO) units to house the disabled. Section 8 certificates and vouchers fund 26 SROs in six localities. (10, p.90)

Delaware. A new initiative has been implemented by the Department of Health and Social Services, Division of Mental Health to develop group homes for mentally ill persons by working with private investors. Under this plan, private investors purchase the housing units and a guaranteed rent is paid by the department for the leases. Another project within the department strives to enhance access to community housing by persons with mental illness. A mental health response team provides all needed services to mentally ill tenants in housing authority units in exchange for the Housing Authority expediting their client's applications. (11)

Louisiana. The East Louisiana State Hospital selected 96 patients from six wards who were capable of living in the community and transferred them to an inpatient unit with a structured transition program. Participants learned to take care of themselves, take their own medicine, and get along with people. Some job training was offered as well. A $271 one-time salary bonus attracted staff to the program. As patients were discharged from the hospital, wards closed and staff members transferred to vacancies in other programs. To support the clients in the community, the hospital

earmarked slightly more than $1 million in hospital resources, or 64 percent of the total costs of institutional care for this group. Funds were accrued by eliminating 80 hospital personnel positions through attrition. After one year of community placment, only 14 percent of the participants have returned to the hospital, compared to a 50 percent recidivism rate for other East Louisiana State Hospital discharges. (10, p. 104)

Massachusetts. As part of a five-year plan to improve services for those with serious mental illness, Massachusetts passed a capital outlay bill that will provide a general obligation bond issue of $340 million to improve the state's mental hospitals and community mental health centers and provide housing for people with serious mental illness. The bond issue will give the state the resources to achieve a balanced system of care that includes first-rate hospitals and comprehensive community services and housing. The legislature will add $110 million to the state mental health agency appropriations over the next five years to cover operating expenses. (10, p. 108)

New York. The New York Legislature authorized a demonstration project in 1978 to test new methods in organizing, financing and delivering mental health services. The Monroe-Livingston County Project in Greater Rochester created a capitated payment system for those with serious mental illness. A private, not-for-profit corporation, Integrated Mental Health Inc. (IMH), was established to serve as a funding pool for funds collected from the state, counties, United Way, and private grants. Capitated payments are distributed on a monthly basis to five community mental health centers that agree to provide or purchase a package of mental health services. Ten percent of the initial payment is deducted and placed in an insurance fund protecting the lead agencies and the capitation payment system program. Because the mental health centers must pay for inpatient care out of their capitated payments, they have a powerful incentive to expand outpatient and residential services to keep clients out of expensive inpatient programs. (10, p. 101)

Ohio. The state of Ohio has implemented several initiatives that maximize federal dollars for community mental health services. Ohio targets $700,000 in mental health subsidy funding each year to be used as a match for vocational rehabilitation dollars for persons with severe mental illness; this $700,000 generates $2.8 million in federal funds. An automated tracking system and state interdepartmental and local agreements ensure compliance in targeting the funds. In addition, state dollars allocated for Medicaid-covered mental health services are used to meet the state matching requirement, which in Ohio is 41.7 percent. The program has grown from $2 million in 1982 to $23 million in FY 1988. (10, p. 88)

Legislation

With declining federal dollars, states are again assuming the major responsibility for the financing and care of mentally ill persons. Over the past few years, there has been a flurry of activity within the state legislatures related to the financing of mental health care.

Alternative Funding Sources. Several states developed alternative funding sources to pay for mental health services in 1987. Alaska (1987 Alaska Sess. Laws, Chap. 48) reconstituted its mental health land trust to fund the state's mental health system. Arizona (1986 Ariz. Sess. Laws, Chap. 398) established the mechanism needed to develop a capitation system of funding services for those with chronic mental illness. California (1987 Cal. Stats., Chap. 945) and Oregon (1987 Or. Laws, Chap. 902) established a check-off on tax returns for Alzheimer's disease programs. Illinois (1985 Ill. Laws, P.A. 84-261) created the Mental Health Education Fund and authorized contributions from tax refunds. A joint effort between New Jersey (1987 N.J. Laws, Chap. 57) and New York uses tourist fee revenue for aid to homeless persons. Rhode Island (1985 R.I. Pub. Laws, Chap. 432) authorized the adoption of rules and regulations to raise funds from private donations for the general hospital.

State Funding Formulas. A variety of states have developed funding formulas to address the issue of financing community mental health services, including: California (1986 Cal. Stats., Chap. 482 and 1985 Cal. Stats., Chap. 1081), Illinois (1987 Ill. Laws, P.A. 85-811), Montana (1986 Mont. Laws, Chap. 124), New Jersey (1984 N.J. Laws, Chap. 435), New York (1986 N.Y. Laws, Chap. 746, 1983 N.Y.

Laws, Chap. 816 and 1974 N.Y. Laws, Chaps. 620 and 621), Texas (1985 Tex. Gen. Laws, Chap. 496), and Wisconsin (1973 Wis. Stats., § 51.42). California provided an equitable means of allocating state mental health funds based upon relative need. Illinois established a pilot program to link the level of mental health care to a capitated rate of reimbursement, based on level of care. New York provided local governments with 100 percent reimbursement for various services provided to deinstitutionalized mentally ill persons living in the community. The Wisconsin Legislature appropriated money for mental health services and allocations are made to each county on the basis of a formula.

Several states passed legislation in 1987 to develop new funding formulas based upon need or severity of mental illness, including: Alaska (1987 Alaska Sess. Laws, Chap. 47), Kansas (1987 Kan. Sess. Laws, Chap. 249) North Carolina (1987 N.C. Sess. Laws, Chap. 738), Texas (1987 Tex. Laws, Chap. 956), Utah (1987 Utah Laws, Chap. 179) and Washington (1987 Wash. Laws, Chap. 105). North Carolina appropriated funds to establish, monitor and administer pilot programs for a new funding policy that targets clients who are most severely impaired. Washington created a new formula for redistribution of mental health funds to counties and will reflect individual county needs assessments.

Family Financial Support. A number of states have laws that encourage family involvement in the financial support of those with mental illness. Florida (1985 Fla. Laws, Chap. 85-253) and Illinois (1986 Ill. Laws, P.A. 1373) established trust funds for the benefit and support of developmentally disabled and mentally ill individuals. The disabled person's income is derived from the funds available in the Florida trust fund and disbursements are made to meet the most common and reasonable unmet needs of the person. The Illinois Self-Sufficiency Trust seeks to ensure the extra care that enhances a mentally ill or developmentally disabled person's quality of life by providing services, such as special therapy, transportation, or recreation, without risking a reduction in the person's governmental aid.

At least 10 states have enacted legislation in recent years to provide assistance or respite to families caring for mentally ill relatives at home, including: California (1987 Cal. Stats., Chap. 558), Connecticut (1987 Conn. Acts, P.A. 432), Illinois (1985 Ill. Laws, P.A. 309), New Hampshire (1987 N.H. Laws, Chap. 32), New Jersey (1987 N.J. Laws, Chap. 119), New York (1987 N.Y. Laws, Chap. 249), North Carolina (1987 N.C. Sess. Laws, Chap. 738), South Dakota (1987 S.D. Sess. Laws, Chap. 203), Texas (1987 Tex. Gen. Laws, Chap. 835), and Washington (1987 Wash. Laws, Chap. 7). Illinois (1985 Ill. Laws, P.A. 309) established a family support demonstration program to encourage families to care for their mentally ill member in the home.

Several states have addressed the issue of paying for mental health services through the collection of fees. In 1987, at least 11 states required clients or family members to pay for at least a portion of service costs. Connecticut (1987 Conn. Acts, P.A. 421) established a uniform contribution scale for liable relatives of persons receiving public assistance or care in a state humane institution. Illinois (1986 Ill. Laws, P.A. 397) provided that parents of a person under the age of 21 shall be liable for medical costs only under certain circumstances. Louisiana (1983 La. Sess. Laws, Act 672) authorized a program of voluntary financial responsibility for family members receiving skilled or intermediate nursing care in an appropriate facility. Maryland (1986 Md. Laws, Chap. 423) authorized the collection of payments for any person who maintains a policy of health insurance under which a recipient of services is insured. New Hampshire (1985 N.H. Laws, Chap. 194) authorized the adoption of rules relative to a uniform schedule of fees and required all community mental health programs to charge all recipients of services the determined fees.

Maximizing Federal Funding. At least eight states increased or expanded Medicaid coverage for mental health services or protected Medicaid funding for institutional care in 1987, including: Arizona (1987 Ariz. Sess. Laws, Chap. 332), California (1987 Cal. Stats., Chaps. 1384 and 1385), Colorado (1987 Colo. Sess. Laws, Chap. 217), Connecticut (1987 Conn. Acts, P.A. 113), Florida (1987 Fla. Laws, Chap. 92), Illinois (1987 Ill. Laws, P.A. 85-873), Iowa (1987 Iowa Acts, Chap. 194) and Wisconsin (1987 Wis. Laws, Act 27). Illinois allows the Department of Mental Health and Developmental Disabilities to receive federal funds under the Medicaid waiver provision of the Social Security Act for providing community services to mentally ill Medicaid recipients. Illinois (1987 Ill. Laws, P.A. 85-609), Maryland (1987 Md. Laws, Chap. 576), Ohio (Vol. 142, 1987 Ohio Laws, H. 171) and Wisconsin (1987 Wis. Laws,

Act 27) passed legislation in 1987 to assist mental health clients in applying for financial assistance programs. North Carolina (1987 N.C. Sess. Laws, Chap. 720) authorized the use of U.S. Department of Defense funds for mental health services to military families. Wyoming (1986 Wyo. Sess. Laws, Chap. 30) authorized Medicaid reimbursement for services provided by certified mental health centers and clinics.

Funding Community Services. Arizona (1984 Ariz. Sess. Laws, Chap. 389), California (1984 Cal. Stats., Chap. 1691), Louisiana (1981 La. Sess. Laws, Act 770), New York (1983 N.Y. Laws, Chap. 61, 1984 N.Y. Laws, Chap. 298 and 1985 N.Y. Laws, Chap. 351) and Washington (1987 Wash. Laws, Chap. 7) addressed the problem of funding residential treatment programs for those with mental illness. In Arizona, the state may require no more than a 25 percent match of local or other funds in the establishment of residential treatment programs. Illinois (1985 Ill. Laws, P.A. 84-383) authorized incentives for nursing homes to develop special programs for Alzheimer's victims. Louisiana established a Community Residential Program Development Fund to provide loans to cover the initial expenditures related to starting community residential programs. New York created the Homeless Housing and Assistance Program to provide funds for housing assistance to the homeless and for emergency shelters. Texas mandated the development of a plan for the reimbursement of rehabilitative residential programs in lieu of more costly programs. Washington appropriated $2.7 million to the Kitsap mental health services residential alternative project and earmarked $500,000 for outreach case management services.

Several states have addressed the issue of financing the construction, renovation or expansion of mental health facilities. Colorado (1983 Colo. Sess. Laws, Chap. 339) authorized county commissioners and city councils to levy a tax for mental health services. New York (1987 N.Y. Laws, Chap. 58) established a debt service fund to be known as the Mental Health Services Fund and authorizes bonds issued to finance mental health services facilities. Texas (1985 Tex. Gen. Laws, Chap. 500) allows the use of funds to renovate existing community center facilities, as well as to construct new facilities, through liens on the center's property. In addition, California (1986 Cal. Stats., Chap. 845), Maryland (1987 Md. Laws, Chaps. 460 and 461, 1986 Md. Laws, Chap. 315 and 1985 Md. Laws, Chap. 542), Massachusetts (1987 Mass. Acts, Chap. 167), Mississippi (1985 Miss. Laws, Chap. 385), New Jersey (1987 N.J. Laws, Chap. 275), New York (1986 N.Y. Laws, Chap. 855) and Tennessee (1986 Tenn. Pub. Acts, Chap. 570) passed legislation that would affect the renovation or construction of mental health facilities. Mississippi authorized the Department of Mental Health to enter into leases with private nonprofit corporations for the construction and operation of one or more group homes.

FUTURE TRENDS AND IMPLICATIONS

Although the focus of treatment has changed in recent years from institutional care to community care, federal and state government funding sources have not shifted correspondingly. The majority of federal dollars are still spent for nursing homes and general hospitals and the vast majority of state dollars are spent on state hospitals. However, financing trends, such as long-term care insurance and capitated care, could produce significant changes in the future reimbursement of mental health care. States will be challenged to create a funding mix for mental health and supportive services and to develop cost-effective program implementation.

With the increasing scarcity of resources to fund programs for those with serious mental illness, states are turning to innovative financing strategies. Capitated managed care programs for mentally ill persons offer one of the most promising ways for states to make the most efficient use of existing funds by controlling excessive inpatient care. Shifting funds from hospital to community services is a clinically sound and fiscally feasible strategy for states to adopt. Recent changes by Congress have created opportunities to provide or maintain services for this disabled population through the use of federal funds. Other approaches that states can take to fund mental health programs include: bonds to finance capital improvements; conversion of state hospital property; and for-profit businesses to subsidize public programs.

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TECHNICAL ASSISTANCE PROGRAM TAPES AND BACKGROUND MATERIAL

Available through the NCSL Mental Health Project are background materials relating to mental health funding. The packet includes a summary of select state legislation, a discussion of model programs, a bibliography, and other relevant information.

If you wish to receive the background information on mental health funding, please copy, complete, and return the form below to the Mental Health Project, NCSL, 1050 17th Street, Suite 2100, Denver, CO 80265.

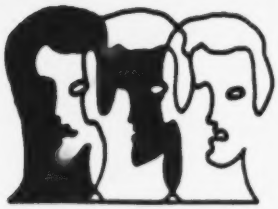
Name: _____

Title: _____

Address: _____

_____

Requesting mental health funding background materials ____



MENTAL HEALTH PROJECT

PROJECT OVERVIEW

In June 1986, the National Institute of Mental Health (NIMH), U.S. Department of Health and Human Services, awarded a contract to the National Conference of State Legislatures (NCSL) to conduct technical assistance programs for state legislators on mental health policy issues from 1986 through 1989.

The goal of NCSL's Mental Health Project is to improve the decision-making ability of state legislators on mental health policy by providing specific assistance to chosen states and disseminating information regarding mental health issues.

During this three-year program, the Mental Health Project will respond to specific issue and format needs of legislators. Under the guidance of the Mental Health Advisory Committee, which is composed of legislators and other persons with mental health experience, Project staff will obtain assistance from expert consultants and state policymakers to provide a variety of services to states, including testimony, special workshops and seminars, and individualized assistance.

Based upon input from the state legislatures, five states will be chosen each year to receive technical assistance on state-specific mental health issues. Along with the programs, the Mental Health Project will develop background materials, audio tapes, and various publications for each issue area. These materials are available free of charge to requesting parties.

The mental health technical assistance program will be offered to the following states during 1987-88:

Illinois	Develop recommendations about community services for mentally ill and developmentally disabled persons
Iowa	Study civil commitment laws to determine whether they should be revised and study the availability of community resources and funding for mental health services
Maine	Review overcrowding at two state inpatient facilities and make recommendations to improve conditions or ensure appropriate community alternatives
Montana	Improve conditions and services at the state hospital to ensure proper care and treatment of patients
Washington	Review overall mental health system, with emphasis on community residential services, involuntary commitment, and funding incentives

The Health and Mental Health Program Manager is Rebecca T. Craig, who may be contacted at NCSL's Denver office (303/623-7800). The acting federal project officer is Vernon James, National Institute of Mental Health (301/443-3606).

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